

❖ Insurance Information

Do you have dental insurance? yes \_\_\_ no\_\_\_ (if yes, please provide the receptionist with a copy of your dental card )

What level of dental care do you think your dental insurance company pays for?

Poor Fair Excellent

What level of dental care would you like to have for yourself?

Poor Fair Excellent

Who is the Insured: Self \_\_\_ Other:\_\_\_ (If other, please provide the following information)

Name of Insured: \_\_\_\_\_

Insured's SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Employer Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

\*\*\*\* We will be happy to file your insurance with verification of coverage, patient co-payments are due at each office visit. My signature below also will act as an assignment of benefits to Dr. Zimmerman and or Brentwood Dental Excellence for any insurance benefits paid and as a signature on file for any other medical and or business processing.

❖ Consent For Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I, also, grant my permission to you and your assignee, to telephone me at home or at my work to discuss matters related to this form. I certify that the above answers are true and correct to the best of my knowledge. I also understand that 2 business days notice is required for appointment cancellations or changes.

\_\_\_\_\_ Date:\_\_\_\_\_

Signature of patient or parent/guardian

Relationship to Patient if applicable; \_\_\_\_\_

In Case of Emergency Whom May We Contact :

Name: \_\_\_\_\_ Tele.# \_\_\_\_\_